ARKANSAS DEPARTMENT OF
Health and Human Services
Division of Child Care & Early Childhood Education

ARKANSAS BETTER CHANCE FOR SCHOOL SUCCESS PROGRAM
2006-2007 HEALTH SCREENING

To Parent or Guardian:

In order to provide the best learning experience for your child, teachers must understand your child's health needs. Therefore, state regulations require that any child enrolled in the Arkansas Better Chance Pre-K program receive a medical check-up. Parents/guardians must also show that the child is current on all immunizations. You need to complete all of the information requested on this side of the form (Part I). Once complete, take this form to your health care provider on the day of your child's check-up. The exam must be done by licensed physician (M.D. or D.O.). Once completed on both sides and signed, return the form to your pre-K program.

Your (Parent/Guardian) Name (Last, First, Middle)	Your Child's Name (Last, First, Middle)	Child's Date of Birth	Sex

Address	City	Zip

Name of Pre-K Program Where Enrolled	Program's Phone Number

Type of Health Insurance	
☐ AR Kids A or B ☐ None ☐ Private insurance ☐ Other:_____	**The participating Arkansas Better Chance program is financially responsible for any health screenings of children not covered by AR Kids or private insurance.**

Part I – To be completed by parent or guardian BEFORE the medical check-up.

Check answers to the following questions. Explain any "yes" answers in the space provided.

	Yes	No	
1.	☐	☐	Do you have any concerns about your child's general health?
2.	☐	☐	Has your child been diagnosed with any chronic disease (such as asthma or diabetes)?
3.	☐	☐	Does your child have any allergies (like to food, medicine or dust)?
4.	☐	☐	Does your child take any medications (daily or occasionally)?
5.	☐	☐	Does your child have any problems with vision, hearing or speech?
6.	☐	☐	Has your child had any hospitalization, operation, major illness or injury?
7.	☐	☐	In the past 12 months, has your child experienced any difficulty with wheezing or night coughing?
8.	☐	☐	In the past 12 months, has your child experienced any excessive weight loss or weight gain?
9.	☐	☐	Has your child had a dental examination in the last 12 months?
10.	☐	☐	Would you like to discuss anything about your child's health with the health care professional?

If you answered "yes" to any question, please explain below. For illnesses or injuries, include your child's age at the time.

Question #	Explanation

Parent Permission and Release.

I give my permission for the information on this form to be used in meeting my child's health and educational needs while enrolled in the Arkansas Better Chance for School Success program.

_____ _____

Signature of Parent/Guardian Date

Part II – To be completed by health care provider. Please complete all sections and sign.

Dear Health Care Professional:

This child is enrolled in the Arkansas Better Chance for School Success (ABCSS) Pre-K program. State regulations require a comprehensive health screening for all ABCSS children. The Division of Child Care and Early Childhood Education recommends an Early Periodic Screening and Diagnostic Treatment (EPSDT) which is age-appropriate. For families enrolled in AR Kids, the cost of the EPSDT for a 1-4 year old may be billed to AR Kids A or B using procedure codes as follows:

Type	< 1 year	1-4 years	5-11 years
New Patient	99381	99382	99383
Established Patient	99391	99392	99393

By law, the ABCSS program is to be free of charge to eligible families. Therefore, the pre-K program under which the child is enrolled is responsible for any costs for families not covered by AR Kids or other insurance. If you have any questions, call the Arkansas Better Chance program at 501-682-9699. Thank you for your assistance.

Weight	Height	BMI	Temp	Blood Pressure
Lb %ile	In %ile	%		/

History Update

☐ Yes ☐ No Any changes in patient health since last visit? Explain_____

☐ Yes ☐ No Any family history of heart disease under 55 years of age?

☐ Yes ☐ No Any family history of abnormal cholesterol?

Health

☐ Good appetite
☐ Drinks lowfat milk
☐ Encourage diet of fruit & vegetables
☐ Limits fast food
☐ Picky or variable eater
☐ Brushes teeth, sees dentist
☐ Encourage active play

Social & Behavioral

☐ Parents discipline, use time out
☐ Dresses self, helps at home
☐ TV and video games are limited
☐ Praised for good behavior
☐ Has friends and playmates

Screenings and Laboratory Results

Test	Result	Date	Comments if abnormal
Vision Test type:	**L**_____ **R**_____		
Hearing Test type:			
TB Risk: Yes / No			
Hemoglobin Risk: Yes / No			
Cholesterol Risk: Yes / No	mg/dL		

PHYSICAL EXAM

	Norm	Abnormal
General	☐	☐
Head	☐	☐
Neck	☐	☐
Eyes	☐	☐
Ears	☐	☐
Nose	☐	☐
Throat	☐	☐
Mouth	☐	☐
Teeth	☐	☐
Lungs	☐	☐
Heart	☐	☐
Femoral Pulses	☐	☐
Genitalia		
Male	☐	☐
Female	☐	☐
Extremities	☐	☐
Gait	☐	☐
Spine	☐	☐
Skin	☐	☐
Neuro	☐	☐

Immunizations

☐ Yes ☐ No All immunizations are current.

☐ Yes ☐ No Child has had all immunizations possible at this time.

Child needs: ☐ DTaP ☐ IPV ☐ HepB ☐ HiB ☐ MMR ☐ Varivax ☐ PCV-7 at _____ yrs/_____mos.

Referrals

☐ Follow-up visit needed in _____ weeks/months

☐ Return check at _____ yrs / mos

☐ Needs to see a dentist—referral will be made by PCP.

☐ _____

Impressions

☐ Well child, normal growth and development

☐ _____

_____, M.D./D.O.

Date_____

CLINIC INFORMATION (or stamp)

Name_____

Address_____

City_____

Zip Code_____ Phone_____